STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 http://www.state.ar.us/dfa/ebd

Authorization for Release of Health Information

Health Plan Participant: _____

Home Address: _____

_____

School / Agency: _____

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:
(School Business Official, Agency Representative, etc.)

_____ _____

The type and amount of information to be used or disclosed is as follows:
(check off appropriate item(s), and include other information, where indicated)

- ❒ Problem List
- ❒ Medication List
- ❒ List of allergies
- ❒ Immunization Record
- ❒ Most recent history and physical
- ❒ Most recent discharge summary
- ❒ Consultation reports from (please supply doctor's names) _____
- ❒ Laboratory results from _____ (date) to _____ (date)
- ❒ Entire record from _____ (date) to _____ (date)
- ❒ Other; please describe: _____

_____

This information may be disclosed to, and used by, the following individuals or organizations: *(providers, spouse, friends, etc.)*

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

See reverse side.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

By my signature below, I authorize disclosures to and by EBD.

This information is being disclosed for the following purpose:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EBD Privacy Officer (on the header address.) I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of this signing.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment enrollment in my health plan, or eligibility for benefits.

_____ _____

Signature of Health Care Participant or Legal Representative Date

_____

If signed by legal representative, print relationship to health care participant

_____ _____

Signature of Witness Date

I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.